SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: Correction Policy Change forms	SERFF Tr Num: SEFL-126264895	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43676
Sub-TOI: H21.000 Health - Other	Co Tr Num: 610 AND 611	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Kristi Hendrickson	Disposition Date: 10/06/2009
	Date Submitted: 10/05/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Correction Policy Change forms	Status of Filing in Domicile: Authorized
Project Number: Correction Policy Change forms	Date Approved in Domicile: 08/12/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments: Approved
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/06/2009	Explanation for Other Group Market Type:
	State Status Changed: 10/06/2009
Deemer Date:	Created By: Kristi Hendrickson
Submitted By: Kristi Hendrickson	Corresponding Filing Tracking Number:

Filing Description:

Form Number Title

75-611-02255 Application for Changes to Health Policy

75-610-01155 Application for Changes to Life Policy

We respectfully ask your review and approval of the above forms. The forms were previously submitted for review under filing numbers 43098 and 43209. They received approval on August 10, 2009 and August 17, 2009.

After these forms were approved, the requirements for changing a policy from tobacco rates to non-tobacco rates was discussed. Because we only require the completion of a Tobacco Use Questionnaire and urine specimen, we have

moved this option to its own section at the top of the form.

This is the only change that has been made to the form. This form has not yet been made available for use; therefore, we ask to keep the form numbers on the form as previously filed and approved.

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	20.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$40.00	10/05/2009	31053834

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
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TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/06/2009	10/06/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/06/2009	10/06/2009	Kristi Hendrickson	10/06/2009	10/06/2009

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Disposition

Disposition Date: 10/06/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Changes to Health Policy	Approved-Closed	Yes
Form	Application for Changes to Life Policy	Approved-Closed	Yes

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/06/2009
Submitted Date	10/06/2009
Respond By Date	

Dear Kristi Hendrickson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Changes to Health Policy, 75-611-02255 (Form)
- Application for Changes to Life Policy, 75-610-01155 (Form)

Comment:

If these two forms are used as a stand alone form/application, the form must contain a Fraud Statement.

A Fraud Statement will not be required if these forms are always used with another application that contains the Fraud Statement.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/06/2009
Submitted Date	10/06/2009

Dear Rosalind Minor,

Comments:
Thank you for your correspondence.

Response 1

Comments: These two forms are for administrative purposes only, for an insured to change their current coverage or remove an exclusion and so on. If health questions or anything attesting to information that would require such a warning would be used we would then use the form approved with the 75-611-02255 under DOI number 43098, which is

the evidence of insurability form 75-859- 05051 and contains the required fraud warning.

Related Objection 1

Applies To:

- Application for Changes to Health Policy, 75-611-02255 (Form)
- Application for Changes to Life Policy, 75-610-01155 (Form)

Comment:

If these two forms are used as a stand alone form/application, the form must contain a Fraud Statement.

A Fraud Statement will not be required if these forms are always used with another application that contains the Fraud Statement.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your time and consideration.

Sincerely,
Kristi Hendrickson

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/06/2009	75-611-02255	Application/ Enrollment Form	Application for Changes to Health Policy	Other	Other Explanation: Correction of Form	50.400	75-611-02255 (08-10).pdf
Approved-Closed 10/06/2009	75-610-01155	Application/ Enrollment Form	Application for Changes to Life Policy	Other	Other Explanation: Correction of Form	50.000	75-610-01155 (08-10).pdf

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Application for CHANGES TO HEALTH POLICY

PLEASE PRINT WITH BLACK INK

Primary Insured's Name _____ Policy No. _____
First *Middle* *Last*

Owner's Name *(if other than Proposed Insured)* _____ Owner's Phone No. _____
First *Middle* *Last*

Effective Date ____/____/____ Changes will be effective as of the current date unless a later date is specified.

☐ Change to Non-Tobacco Rates *(A Tobacco Use Questionnaire and urine specimen with a paramedical firm will be required.)*

All changes in this section require completion of an Evidence of Insurability form, a signed Confidential Information Authorization form and signature by the Insured and the Policyowner *(if other than the Insured)*.

☐ Remove Exclusion List exclusion _____

☐ Remove/Reduce Extra Premium Rating

☐ Exercise Flex Renewal Option* *(Complete a Financial Underwriting form. Complete the forms listed above only if required.)*

☐ Increase the Rider Benefit Amount

Name of Rider	Insured's Name *(if applicable)*	From	To
		$	$
		$	$

☐ Add Rider(s)*

Name of Rider(s)	Proposed Insured's Name	Rider Amount
		$
		$

☐ Add Coverage on my Spouse/Dependent Child(ren)*

Name	Relationship	Rider Amount
		$
		$

☐ Other *(Please specify)* _____

*This option is not available on all plans. Contact the Assurity administrative office to determine eligibility.

All changes in this section require the Policyowner's signature only.

☐ Increase the Elimination Period from _____ days to _____ days

☐ Decrease the Benefit Period from _____ to _____

☐ Decrease the Benefit Amount on the:

	From	To
☐ Base Policy	$	$
☐ Supplemental Disability Income Benefit	$	$
☐ Flexible Monthly Benefit Amount	$	$
☐ Rider Name of Rider _____	$	$

☐ Remove Rider(s)* *(List each rider below)*

_____

☐ Remove Spouse/ Child(ren) List name(s) _____

☐ Other _____

*Not all riders can be removed without termination of the Policy. Contact the Assurity administrative office for more information.

Date (MM/DD/YYYY)	*Signature of Primary Insured*	*Signature of Other Insured (if applicable)*
Date (MM/DD/YYYY)	*Signature of Witness/Licensed Agent*	*Signature of Policyowner (if other than Primary Insured)*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Application for CHANGES TO LIFE POLICY

PLEASE PRINT WITH BLACK INK

Primary Insured's Name _____ Policy No. _____
First *Middle* *Last*

Owner's Name *(if other than Primary Insured)* _____ Owner's Phone No. ( ) _____
First *Middle* *Last*

Effective Date ___/___/___ Changes will be effective as of the current date unless a later date is specified.

☐ Change to Non-Tobacco Rates *(A Tobacco Use Questionnaire and urine specimen with a paramedical firm will be required.)*

All changes in this section require completion of an Evidence of Insurability form, a signed Confidential Information Authorization form and signature by the Insured and the Policyowner *(if other than the Insured)*.

☐ Add Rider(s) Name of Rider(s) Proposed Insured's Name Rider Amount

_____ _____ $ _____

_____ _____ $ _____

☐ Add Paid-Up Additions Purchase Option Rider (VER)

☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

☐ Add Payor Benefit Rider Full Name of Payor _____

Address of Payor _____

Date of Birth *(MM/DD/YYYY)* ___/___/___ List Occupation and Duties _____

☐ Add Waiver of Premium List Occupation and Duties _____

☐ Add Accidental Death Benefit Rider Rider Amount $ _____

☐ Use dividends accumulated at interest to purchase Paid-Up Additions *(If Paid-Up Additions purchased are less than $5,000, it is not necessary to complete an Evidence of Insurability form or a Confidential Information Authorization form.)*

☐ Remove/Reduce Extra Premium Rating ☐ Other *(Please specify)* _____

Universal Life Policies Only

☐ Change Death Benefit Option from #1 *(level)* to #2 *(increasing)* ☐ Increase Base Policy Face Amount from $ _____ to $ _____

Special Instructions/Comments

All changes in this section require the Policyowner's signature only.

☐ Reduce Base Policy Face Amount from $ _____ to $ _____

☐ Remove Rider(s)* List Rider Name(s) _____

☐ Reduce Rider Benefit Amount

Name of Rider Insured's Name *(if applicable)* From To

_____ _____ $ _____ $ _____

_____ _____ $ _____ $ _____

☐ Other _____

Universal Life Policies Only

☐ Change Death Benefit Option from #2 *(increasing)* to #1 *(level)*: ☐ Maintain current Benefit ☐ Change Benefit to base policy Face Amount only

☐ Change Planned Premium from $ _____ to $ _____ Payment mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Automatic Monthly

*Not all riders can be removed without termination of the Policy. Contact the Assurity administrative office for more information.

_____ _____ _____
Date (MM/DD/YYYY) *Signature of Primary Insured* *Signature of Other Insured (if applicable)*

_____ _____ _____
Date (MM/DD/YYYY) *Signature of Witness/Licensed Agent* *Signature of Policyowner (if other than Primary Insured)*

SERFF Tracking Number:	*SEFL-126264895*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43676*
Company Tracking Number:	*610 AND 611*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Correction Policy Change forms*		
Project Name/Number:	*Correction Policy Change forms/Correction Policy Change forms*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/06/2009
Comments:			
Attachment:			
READ CERT-refile.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/06/2009
Bypass Reason:	N/A this is a filing for administrative forms for the insured to request changes.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	10/06/2009
Bypass Reason:	N/A this is a filing for administrative forms for the insured to request changes.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/06/2009
Bypass Reason:	N/A this is a filing for administrative forms for the insured to request changes.		
Comments:			

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word 2007 program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Type of Form: **Policy Change and Evidence of Insurability**

Form No.	Description	Flesch Score
75-611-02255	Application for Changes to Health Policy	50.4
75-610-01155	Application for Changes to life Policy	50.

Carol S Watson
Signature

October 5, 2009
Date

Carol Watson
Vice President, General Counsel
Secretary